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ABSTRACT

Drug abuse among white ethnic adolescents is described in this report. Focusing on the framework of economic and social factors that affect the inner-city white adolescent, the report attempts to integrate this information with available mental health studies related to drug taking behaviors. The results from the National Polydrug Study which differentiated drug use by race are presented. In addition, the report reviews data gathered by the National Center for Urban Ethnic Affairs on white ethnic drug abuse. These two studies provide data on types of drugs used, frequency of use, sex and age of users, and use by each ethnic group. The report concludes that rates of drug use among white ethnic adolescents are as high as among non-whites. (Author/APM)

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Drug Abuse Among White Ethnic Adolescents

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The National Center for Urban Ethnic Affairs
Washington, D.C.

Since its founding in 1970, The National Center for Urban Ethnic Affairs (NCUEA) has been actively engaged in advocacy for the ignored and neglected population of older industrial cities. NCUEA is involved in all phases of the neighborhood movement—the founding of community based organizations, building the capacity for neighborhood development and revitalization, promoting artistic, educational and cultural development, and transfering the insights and techniques which prompt civic renewal.

This NCUEA publication extends the NCUEA series of action/research reports which explore the significance of the ethnic factor for urban America. NCUEA trusts that an open discussion of painful issues will allow us to develop a wholesome society in which the needs of the individual are balanced with the purposes of the community. In this regard, our agenda and mission is to examine the ignored and neglected aspects of cultural diversity which are related to health, education, family, friends and language. NCUEA affirms the hope that thoughtful reflection on the perduring character of ethnic diversity will enable urban communities to clarify and to address important public policy questions facing America.

Dr. John A. Kromkowski
President
The National Center for Urban Ethnic Affairs

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Drug Abuse Among White Ethnic Adolescents

by John A. Carlisi

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Washington, D.C.

Introduction

Adolescent drug abuse has traditionally been viewed primarily as a problem of inner-city Black and Hispanic youth who come from an environment of severe economic and social deprivation. It has been thought that their drug abuse has resulted in the most severe costs to society. Consequently, substantial resources have been spent over the past few years in establishing programs specifically designed to cope with the problems of Black and Hispanic youths.

Yet, secure in the feeling that they had identified the major drug users, the policy makers have ignored an important phenomenon—the emergence of the White ethnic adolescent drug users. This study will examine drug use among the White ethnic population, explore some possible causes and make recommendations for required prevention and treatment services.

In recent years, there has been a tremendous increase in interest in drug abuse among "special populations." Much research has been undertaken which focuses on the question of ethnic/cultural factors in drug use and the provision of appropriate treatment. These studies have focused on Black, Hispanic, Native American and, to a small extent, Oriental populations but have totally ignored the White ethnic. Many of these ethnic/cultural studies have significantly influenced perceptions of the cause and treatment of drug abuse because they have all pointed to a diversity of factors among the different populations which require specialized responses. It is the contention of this book that there are differentiating factors at work in the White ethnic population and that these must be fully explored to make prevention, intervention and treatment services more responsive to individual needs.

There has been a paucity of studies which even describe the use of drugs among White ethnics; thus, for many readers this book will explore new areas. As such, the book attempts to describe a framework of the economic and social environment of the inner-city White ethnic adolescent, integrate the minimal number of mental health studies which are even peripherally related to drug taking behaviors, explore a significant drug study which differentiated drug use by race, and describe the results of the study developed by the National Center for Urban Ethnic Affairs (NCUEA) in this area.

If the ideas generated in this book seem basic and exploratory in nature, it is important for the reader to remember that up to this point, no major studies had been conducted in drug abuse which even measured the incidence and prevalence of drug abuse among the White ethnic population, much less addressed possible correlatives.

In the present study, we found that the rates of drug use among White ethnic adolescents were as high as among non-Whites; there were significantly different patterns of drug use among White ethnics; relationships with parents among all ethnic groups differed sharply between

users and non-users; and that treatment facilities were not providing adequate services to White ethnics.

Ethnicity

The concepts of "ethnicity" and "ethnic identity" have been analyzed extensively by social scientists and community activists over the past decade. For the purpose of our discussion of the prevalence of drug use by White ethnic adolescents, we will begin by exploring some definitions of the concept of ethnicity.

Talcott Parsons (31) defines ethnicity as:

> . . . a primary focus of group identity, that is, the organization of plural persons into distinctive groups, and second, of solidarity and the loyalties of individual members to such groups.

Factors integral to a sense of ethnicity, according to Parsons, include racial homogeneity within the particular group; a certain degree of religious uniformity; linguistic conformity; and a common cultural tradition. One area of divergence may be class because there are major socioeconomic stratifications within ethnic groups. Parsons describes an ethnic group as

> . . . a group, the members of which have, both with respect to their own sentiments and those of non-members, a distinctive identity which is rooted in some kind of a distinctive sense of its own history.

Parsons further states:

> American society, on the one hand by virtue of its political constitution, on the other hand by virtue of the history of immigration, pioneered in the establishment of a multi-ethnic society. If there is a single formula for ethnic identity in the American population, probably the conception of "national origin" is the most accurate designation for most groups.

Ethnicity is considered to be an important factor in the development of an individual's personality. Glazer and Moynihan (8) have compared the impact of ethnic awareness on identity to that of the industrial revolution and assert that:

> There has been a pronounced and sudden increase in many countries and in many circumstances to insist on the significance of their group distinctiveness and identity and on new rights that derive from their group character.

In addition to being a source of individual identity, ethnicity has also become a major organizing principle, more powerful than class and providing an easier concept on which to relate. Again, Glazer and Moynihan (8) point out:

> Different groups *do* have different norms. In the most natural way the unsuccessful group has the best chance of changing the sys-

tem if it behaves *as a group*. It is *as a group* that its struggles become not merely against the norms of some other groups, but in favor of the already established norms of its own.

Ethnicity as a Factor in Mental Health

Any factor with such a heavy impact on an individual's development and personality must also relate to that person's mental health. There is ample evidence which implies that social class plays some part in mental health processes, although there is a paucity of literature relating to ethnicity, social class, and drug abuse *per se*. However, drug abuse is an established correlative of mental health problems. (19, 33).

The relationshp between mental health and ethnicity is noted by Opler (30) in his review of the work of Mead, Benedict, Kluckholm, Sullivan, Horney, Frenczi and Kardiner, all of whom stressed the influence of social and cultural environment on normal and deviant behavior. The work of Kolodny (17), Spiegel (36), Barrabe and Von Mering (1) and Zborowski (41) suggest that various ethnic groups differ in their response to health, illness, and treatment. However, Kolm (16) indicates there is a lack of empirical evidence which links treatment utilization patterns to ethnic variation. Gurin (13) and Stole's (37) work along with Leighton (20) and Phillips (32) has shown that as much as 50 percent of persons with emotional problems never seek and/or receive any kind of help. Our own experience indicates that the percentages are at least as high in the ethnic neighborhoods. The classic work of Holingshead and Redlich (14) bridged the gap between mental health and class by raising two fundamental questions: 1) Is mental health related to class? 2) Does a patient's position in the status system affect the treatment he/she receives?

One conclusion drawn from their study was that occupation is a potent force in determining a person's general life adjustments and the ways of coping with problems. This conclusion is also supported by the Midtown Manhattan study (37) and the Gurin, Veroff and Field (13) nationwide survey of 2,460 adults.

The work of Kornhauser (18), Mills (25) and Fromm (5) support this hypothesis and strongly imply that occupation has important consequences for a person's ego strength. It can be conjectured from these investigations that the world of semiskilled and unskilled blue collar workers produces a life situation of deprivation, insecurity, powerlessness and low self-esteem regardless of race or ethnicity. Poor self-image and low self-esteem are factors often cited in drug abuse (4, 22, 40).

Giordano's (6) review of the literature suggests that ethnicity has at least as powerful an impact on mental health as social class. He points out that the influence of ethnicity becomes particularly significant in those studies where social class is held constant. (All of the neighborhoods in this study are both ethnic and working class.) Giordano notes that while professionals have already accepted class differentials, ethnic variation is still often ignored or worse, denied outright.

Giordano (7) summarized the role played by ethnicity, as follows:

1. Ethnicity and ethnic identity have been generally ignored as

having significant influence on the mental health of Americans.

2. There are marked differences in how various groups perceive and use mental health services.

3. When mental health practitioners are unaware of the difference in emotional language, family symbolism, and the variation of family roles, the quality of treatment is likely to suffer. The practitioner's background differs radically from that of the patient, or family, producing a variety of distortions.

4. There is a wide inequality of mental health services that are given, depending both on class or ethnic differences. Suffering from the same illness, those in the lower classes are more often hospitalized and treated with pills and electro convulsive therapy than middle and upper classes, who receive psychotherapy.

5. Numerous studies have indicated that many working class ethnic communities are drastically underserved in terms of their mental needs. Family breakup, alcoholism and addiction, youth, disorganization—and more "normal" needs such as counseling, emotional support during adolescence and experience toward personal growth and self development—these are generally not dealt with adequately by mental health agencies in working class communities.

6. The current mental health systems are fragmented and uncoordinated. This results in duplication and gaps in needed services.

From the above we can see that ethnicity is a powerful determinant in the development of the individual. This fact alone should make it a significant consideration in prevention, intervention and treatment. But we must also remember that inner city White ethnic adolescents come from a similar economic and social environment as Blacks and Hispanics. The implications of this will be explored in the next few paragraphs.

Characteristics of Inner City Ethnics

Despite the current trend for young professionals to move back into the city, the core populations are composed predominantly of Black, Hispanic, and White ethnics from the lower and lower-middle socio-economic strata (11). Each of these groups tends to live in its own geographically and culturally defined area; yet these areas are often in close proximity to each other.

American Catholic ethnics are generally concentrated in the northeast, mid-Atlantic and midwest areas. These regions have 80% of the nation's French Canadians, 88% of the nation's Italians, 87% of the Poles, and 84% of the Irish Catholics (11).

The belief that these ethnic groups have lost their identity and gained a new one is, of course, the "melting pot" theory. Even if one assumes the validity of that theory (which is increasingly being questioned by sociologists), census data indicate a large base of first and second generation people in most Catholic ethnic groups, particularly those of Eastern and South European identity.

PERCENT CATHOLIC ETHNIC GROUPS WHICH ARE FIRST AND SECOND GENERATION IN THE UNITED STATES
1970 Census

English	31
Irish	31
German	35
French-Canadian	54
Polish	66
Eastern European	77
Italian	84
Spanish-speaking	88
Lithuanian	90

Although the nine groups range from 31 to 90 percent first and second genration, six of the nine are well above 50 percent. Only the English, Irish and German are primarily third generation and later. With few exceptions, such as the Irish Catholic neighborhoods of Chicago, Boston and New York, these third generation groups are not in the neighborhoods of the central cities in significant numbers nor in identifiable cultural enclaves.

The neighborhoods in which the Southern and Eastern European populations live are generally characterized by the following (all figures based on the 1970 Census unless otherwise noted):

- A high rate of religious (Roman Catholic) homogeneity compared to surrounding areas.

- Concentration of other White ethnic groups of different religions, primarily Eastern, Russian and Greek Orthodox, Jewish in some areas and, in recent years, large numbers of White Appalachian Baptist.
- A cultural link to the religion, values and mores of the original immigrant stock.
- Close geographic proximity to the inner-city Black neighborhoods.
- A level of income averaging 15.3% below that of the SMSA but 34.5 above the adjacent Black areas.
- A median education level of 10.4 years compared to 11.9 for SMSA and 9.6 for the adjacent Black population.
- The highest rate (77.5%) of housing built before 1939.
- A 43.4% rate of owner occupied housing compared to 57.4% for the SMSA and 27.8% for the nearby Black population.
- A significant neighborhood stability as evidenced by the highest percentage of people residing in their neighborhood since 1949 or earlier and high rate of elderly, widowed or divorced individuals.
- High rates of blue collar, and low rates of white collar and government employment.

As we see from the above, White and non-White ethnics share many experiences in common, yet there are significant areas of difference which are important to identify because of their implications for prevention, intervention and treatment. Further, there are specific characteristics which can be attributed to particular White ethnic neighborhoods. As an example, past NCUEA experience has yielded the following profiles of Polish and Italian neighborhoods.

CHARACTERISTICS OF POLISH AND ITALIAN ETHNIC NEIGHBORHOODS

POLISH	*ITALIAN*
Patriarchal Family Structure	Matriarchal Family Structure
Strong Church Affiliation	Moderate Church Affiliation
Predominant Blue Collar Worker	Predominant Blue Collar Worker
Presence of Foreign Language	Presence of Foreign Language
Modest Family Income	Modest Family Income
Average Female Labor Force	High Female Labor Force
High non-Public School Enrollment	Low non-Public School Enrollment
High Owner Occupied Housing	Low Owner Occupied Housing
High Residential Stability	High Residential Stability

In general, in these ethnic communities there is convergence in occupational identity, use of foreign language, family income and residential

stability. Differences suggest that attitudes toward neighborhood institutions (primarily educational and religious), patterns of authority, home ownership and female employment differentiate Polish and Italian working class neighborhoods.

Vaillant (38) observed that minority group membership correlated with probability of hospitalization for addiction, and that the highest risk was among the first generation children of minority immigrants, not among the immigrants themselves. Of more general significance was the finding that the delinquency *per se* may be correlated with first generation status (Glueck and Glueck, cited by Vaillant (38). It is possible that the development of antisocial behavior is related to the disparity, and therefore potential conflict, between the values of the parents and those of the dominant culture. These disparities lead to transitional states in which values are shifting, deculturation and acculturation stresses have to be borne, and possible feelings of alientation from both cultures are engendered.

The present study found significant differences in the prevalences of drug use among the larger ethnic groups identified. When specific White ethnic groups were analyzed, there was strong evidence that the use of drugs on a regular basis was highest in the Irish population. Italians in contrast were heavily involved with the occasional use of alcohol, heroin, illegal methadone and tranquilizers.

In the next few paragraphs we discuss some of the studies which have looked at race, at best a proxy for ethnicity, as a factor in drug abuse.

Racial Differences in Drug Use

Several studies have explored race as a factor of drug use, although the degree to which racial and other sociodemographic variables have been successfully differentiated is not always clear. In recent years, race-related (Black-White) differences in prevalence appear to have diminished or, in some cases, to have reversed (29).

In a 1976 study, White youths born in 1953-54 reported higher rates of use than Blacks of sedatives, stimulants, psychedelics and heroin, reversing earlier reported ratios. In measuring current drug use, there appeared to be a racial convergence of prevalence rates which was most notable for the drugs traditionally used by larger proportions of Blacks: marijuana, opiates and cocaine. For example, current use of marijuana among the youngest age cohort of men was 51 percent for Blacks and 49 percent for Whites as contrasted with 39 and 21 percent, respectively, for Black and White men born about 20 years earlier. More importantly, the prevalence of lifetime marijuana use was equivalent for Black and White youths born in 1953-54, but was higher in Blacks than Whites among older groups of men. In the youngest age cohort, 10 percent more Whites than Blacks used sedatives whereas there was no race-related difference in sedative use among the oldest men sampled. (29)

Kandel's (15) study among high school students in New York State showed Whites were more likely than Blacks to have tried alcoholic beverages, marijuana, pills, psychedelics and inhalants, but less likely to have tried cocaine or heroin. These data suggest that Black youths begin experimenting with drugs at older ages than White youths, an observation also made in the present study. This pattern does not hold for other non-White ethnics, most extremely among Native American girls.

Kandel et al. (15) also reported that Hispanic high school students in New York State were less likely than either Whites or Blacks to have tried alcohol, cigarettes or marijuana; yet they were intermediate in likelihood of having tried pills, psychedelics and heroin, and were more likely to have tried cocaine. This is also corroborated in the current study.

Although Native American students constituted only a small subsample in the Kandel study, the results bear noting. Members of this group were most likely, often by large percentage differentials, to have tried all psychoactive drugs, except heroin again, paralleling the results to be reported here. Orientals, who also constituted a small subsample have in other studies (34) consistently shown dramatically lower rates of drug use compared to all other ethnic groups.

We have thus far reviewed several of the factors which provided the basis of the current study. In the following pages we will discuss the results of the National Youth Polydrug Study and look at the NCUEA study in detail.

National Youth Polydrug Study

There has been one recent study of adolescent drug use which collected data on White ethnicity—the National Youth Polydrug Study (28) conducted by the Philadephia Psychiatric Institute. This study used as its sample adolescents—18 years or younger—who had been admitted to treatment in various facilities in the Philadephia area. In the demographic section of the questionnaire an open-ended question concerning ethnicity was posed: "What ethnic group do you identify with?" Not surprisingly, many of the respondents chose not to answer the question or picked answers that were not particularly accurate: "White," "American," North American," etc. Nevertheless, the Institute staff was able to extract a sample significant enough for analysis.

The composition of the NYPS White sample of 667 respondents was 57% Americans—which includes Polish and Jewish, samples too small to analyze separately—17% German, 15% Irish and 11% Italian. Males predominated in each group ranging from a low of 52% in the Italian population to a high of 65% in the American. A huge majority, 98 percent, of the respondents had never been married, 64 percent were currently unemployed, 28% had part-time work and 75% lived with their parents. One-third of the sample classified heads of their household as being semi-skilled or unskilled; over 60 percent reported skilled worker, clerical/technical or administrative/manager; and five percent cited executive or professional. Religion tended to have a bimodal distribution; Americans and Germans tended to be predominantly Protestant while the Italians and Irish reported Catholic. Approximately one-quarter of the sample reported no religious preference. From the information provided we can see that this sample is composed of lower middle and middle-class adolescents who have close ties to their family and are substantially unemployed.

To discern the extent of the serious drug use in this population, we focused on the extent of the regular/heavy—defined as three times or more weekly—substance use in each of the populations. This data is shown in Table 1, below.

Table 1
Regular/Heavy Drug Abuse by White Ethnic Groups, NYPS Sample

Substance	Americans	Italians	Irish	Germans	Total White
Alcohol	26.1%	23.7%	12.4%	17.5%	18.5%
Marijuana/Hashish	48.4	38.2	44.3	48.2	46.6
Barbituates	7.6	7.9	7.2	4.4	6.3
Amphetamines	5.4	3.9	5.2	2.6	5.1
Heroin/Other opiates	3.8	11.8	5.2	0.9	4.2
Illegal methadone	0	2.6	0	1.8	0.7
Inhalants	1.1	1.3	3.1	0	1.5
Tranquilizers/Sedatives	5.4	7.9	6.2	2.6	4.9
Hallucinogens	2.2	1.4	3.1	0.9	1.5

Clearly, the substance most extensively used on a regular basis is marijuana/hashish followed at some distance by alcohol. Other data (28) have indicated that alcohol is the most popular occasionally used substance even in this 18 and under population. Prevalence of marijuana and alcohol use is followed in decreasing order by barbituates, amphetamines, tranquilizers, heroin and lastly inhalants, hallucinogens and illegal methadone.

While the American adolescents report higher rates than the Irish in alcohol, marijuana and barbituates (with amphetamine use being statistically equal), the Irish youths showed higher rates of tranquilizer/sedatives, heroin and inhalants use. It is interesting to note that in neither population was illegal methadone reported to be used.

The Italians in the sample had rates of use which were higher than total White population ratios in five categories. While reporting the second highest rate of regular alcohol use and the lowest rate for marijuana/hashish, the Italian adolescents report the highest rates of any population for the use of barbituates, heroin/opiates, illegal methadone and tranquilizers—all depressants.

In the sampling, the German youths reported the lowest overall rates of use—two rates higher than the population out of nine—but they reported one of the highest rates of marijuana use (not statistically different from Americans) and substantial illegal methadone use.

At this point we see that even in a study whose primary emphasis did not differentiate drug use among White ethnic groups, very specific patterns can be discerned. In the study conducted by us, we explored this phenomena to an even greater degree.

The Current Study

The data gathered for the NCUEA study was obtained through a 196-item questionnaire. The questionnaire was developed and field tested in August and September 1975 and was administered in November 1975. Four inner-city communities, one each in Baltimore, Cincinnati, Detroit and Providence, were chosen because of the existence of specific White ethnic groups. The questionnaires were administered under the aegis of local community organizations with which the NCUEA has had extensive working relationships.

In Baltimore and Detroit local high schools were contacted for participation in the study. The anonymous questionnaires were administered to all home room classes. In Cincinnati and Providence, the local high schools and Board of Education refused to cooperate in the study which necessitated the use of an extensive outreach effort to neighborhood youth.

The alternative strategies required in Cincinnati and Providence necessitated that smaller samples be taken. Appreoximately 1400 useful questionnaires were obtained with the following distribution:

Table 2
City of Distribution Sample Number

City	Per Cent of Sample
Baltimore	30%
Cincinnati	13%
Detroit	44%
Providence	13%

Questionnaires were considered useful if there were no internal inconsistencies in drug use patterns, if enough variables were answered to provide a sociodemographic and ethnic identification and more than 95% of the other required information was completed.

The total sample ranged in age from 15 to 22 years old. For purposes of this book we will concentrate on the subsample which is 18 years and younger. In order to gain a perspective of how this age group compares to the whole sample the following tables shows the relevant data by city:

Table 3
Age Distribution of Sample by City

		Percent of Sample		Average Age of Subsamples	
	Average Age of Total Sample	18 years or younger	Over 18	18 years or younger	Over 18
Baltimore	17.4	74.1%	25.9%	16.5	20.0
Cincinnati	17.9	63.0%	37.0%	16.6	20.1
Detroit	16.9	86.2%	13.8%	16.3	20.6
Providence	17.5	68.6%	31.4%	16.4	20.0
Total	17.3	77.3%	22.7%	16.4	20.2

The average age of the 18 and under population was 16.4 years and the over 18 was 20.2. Over three-fourths of the sample (77.3 percent) were 18 or under, ranging from a low of 63.0% in Cincinnati to a high of 86% in Detroit. The average age of the whole sample is 17.3 years with the Detroit group being the youngest (16.9) and Cincinnati being the oldest (17.9). The total sample was 55% male and 45% female. The following table shows the detail of this distribution by city in the 18 year old and younger subsample where 54% are male and 46% are female.

Table 4
Distribution by Sex and Age by City

City	18 Years Old and Younger	
	Male	Female
Baltimore	61.7	38.3
Cincinnati	53.8	46.2
Detroit	48.2	51.8
Providence	57.9	42.1
Total	53.7%	46.3%

Over three-quarters (76.6%) of the 18 and younger group were concentrated in the ninth; tenth and eleventh grade. Of the sample 18.8% did not currently go to school. Of the fathers of the 18 or under respondents, 36.3% worked as mechanics or laborers, 7.6% owned their own business while 34.9% looked after the home, 9.7% held clerical positions and 9.5% worked as laborers. The population in the sample is clearly blue collar and representative of the lower to middle socio-economic strata and is similar to the youth in the NYPS sample.

The neighborhoods we surveyed have many different ethnic groups living in close proximity to each other. Rather than ask respondents what particular ethnic group they identified with, we asked for the specific ethnicity of both parents. We found that there were four specific White ethnic groups which could be identified in a significant sample: Polish, Italian, German and Irish. Two other White ethnic populations were also defined.

- Both parents were White, of the same ethnicity, but were not Polish, Italian, German or Irish. (White Same, WS)
- Both parents were White and of different ethnicities. (White Different, WD)

There were also significant Black, Hispanic and Native American populations in these communities as well as a large number of racially mixed children. The following table shows the ethnic composition of the 18 and under population for each of the communities studied:

Table 5
Ethnic Composition of Sub-Samples—
Number of Respondents by City

Ethnicity	Symbol	Detroit	Baltimore	Cincinnati	Providence	Total
White parents of same ethnicity	WS	10	42	12	7	71
Both white parents of different ethnicities	WD	78	66	15	36	195
Polish	P	146	25	0	0	171
Italian	It	2	12	0	58	72
Irish	Ir	9	14	1	5	29
German	G	4	15	3	1	23
Black	B	134	25	1	1	161
Hispanic	H	49	11	2	0	62
Native Americans	NA	7	40	20	0	67
Racially Mixed	RM	17	32	11	4	64
Total		456	282	65	112	915

The adolescent sample in the NCUEA sample is 61% White ethnic, 32% non-White and 7% racially mixed. The ethnic populations in this study are distributed unevenly among the four communities. Detroit has the highest concentration of Polish, Black, Hispanic and WD respondents; Baltimore is a polyglot neighborhood with some concentration in WD, WS, RM, NA and highest sample of Irish and German; Providence is predominantly Italian and WD; Cincinnati is primarily NA, WS, WD and racially mixed.

The group designated as White Same (WS), composed of respondents whose parents have the same White ethnic background, is distributed as follows:

Table 6
Composition of White Same (WS)
Ethnic Group

	Number of Respondents; All Cities
English, Scotch Welsh English Canadian	19
French, French Canadian, Belgian	4
Greek	10
Hungarian, Slovakian, Latvian	16
Jewish	8
Russian, Ukranian	13
Swiss	1
Total	71

Measures of Drug Use

The extent of drug use among the specific ethnic groups was based on three criteria:

- Percent of friends who use
- Greatest level of self-use, ever
- Greatest level of self-use, past two months

The most important measurements in this report will involve recent (past two months) use of drugs with friends' use being a secondary measure. The question of "ever used" was incorporated as a check to the recent use response. Frequency of use was established for the nine groups of drugs. Usage for each drug was characterized in six categories:

1. Not at all
2. Less than once a week
3. About once a week
4. Several times a week
5. Once a day or almost daily
6. More than once a day

For several of the analyses which were conducted for this study, it was necessary to convert these nominal scales to ordinal values. It was decided that each of the categories should be converted to an index of drug use over a two-week time-span.

The weights assigned (see below) were corroborated by additional field interviews with respondents. For each of the six categories, the weight was calculated by the following:

$$\text{Weight of category} = \frac{\text{assigned frequency over two weeks}}{14 \text{ days}} \times 100$$

The calculation yielded the following approximate index:

Category	*Formula*	*Index*
1. Not at all	0/14 × 100	0
2. Less than once a week	(1/14) × 100 = 7.14	7
3. About once a week	(2/14) × 100 = 14.9	14
4. Several times a week	(7/14) × 100 = 50	50
5. Once a day or almost daily	(14/14) × 100 = 100	100
6. More than once a day	(28/14) × 100 = 200	200

The values obtained yield a measure of drug use per 100 user/days which will serve as a basis for comparing the drug use rates among the 10 specific ethnic populations. The outcome of the surveys will be discussed in five groups:

- A comparison between the NCUEA 18 and younger population and the NYPS cited earlier.
- A comparison of NCUEA White and non-white populations.
- A comparison between the NCUEA and younger population and the NCUEA 19 and older population.
- A discussion of the prevalence rates in the NCUEA White ethnic 18 and younger sample.
- An analysis of correlative factors in the regular/heavy drug use of the NCUEA 18 and younger population.

NCUEA and NYPS Comparison

In the examination of the regular/heavy drug usage patterns for four White ethnic groups: Americans, Italians, Irish, Germans, we find striking parallels to the NYPS sample described earlier. In this analysis, the NCUEA samples of WS, WD and Polish have been combined to be an approximation of the NYPS "Americans" category. The Polish sample in the NCUEA survey is included because the NYPS survey did not have a significantly large designation of Polish, the largest NCUEA White ethnic group. This discussion will compare the regular/heavy usage patterns for each of the four White ethnic groups based on the following drugs: alcohol, marijuana/hashish, barbituates, amphetamines, heroin/other opiates, illegal methadone, inhalants, tranquilizers/sedatives and hallucinogens.

Keeping in mind that the NYPS sample is composed of adolescents who have been admitted to treatment programs and the NCUEA sample is in the general population, we assume that the NCUEA population will have lower prevalence rates. However, there are some interesting similarities in use patterns. In both populations marijuana is the most often heavily used drug (NCUEA: 30.9%; NYPS: 46/6%) while alcohol is second (21.9%; 18.6%). Barbituates and amphetamines are the third and fourth frequently used in both samples. Illegal methadone and hallucinogens are the least used drugs.

Two major differences occur with heroin and inhalants. Heroin use in the NYPS sample is relatively large (4.2%) compared to the NCUEA group (1.3%); conversely inhalant use in the NCUEA sample (3.4%) is over twice that in the NYPS sample (1.5%). Ther heroin use discrepancy can probably be attributed to the fact that the NYPS sample was in treatment; we have no explanation for the difference in the use of inhalants.

We can see the similarity of the samples by using a rank correlation to compare one to the other. Table 7 shows how each substance ranks in each sample based on the measurement of current regular/heavy usage.

Table 7
Rank of Substance Use
NCUEA Compared to NYPS Sample

Substance	NCUEA	NYPS
Alcohol	2	2
Marijuana/Hashish	1	1
Bartituates	3	3
Amphetamines	6	4
Heroin/Opiates	8	6
Illegal Methadone	7	8
Inhalants	4	7
Tranquilizers/Sedatives	5	5
Hallucinogens	8	7

The rank correlation coefficient (r) in equal to .84 which is statistically significant ($p < .03$). Thus even though the percentages may be distorted because of the sample composition, the samples can be considered roughly comparable.

Use Rates by White Ethnic Groups

Distinct patterns of use emerge within the four ethnic groups. Irish adolescents are clearly the heaviest users in both samples—with all of their use rates higher than the total sample—followed very closely by the "Americans." Italians and Germans exhibit patterns which are markedly lower than the total sample in the NCUEA sample and somewhat lower in the NYPS sample. The data show an almost universal pattern of more marijuana/hashish use than alcohol use except in the NCUEA "Americans" sample. After that the usual groups of barbituates, amphetamines and sedatives/tranquilizers are followed by lower rates of usage of other substances.

Irish. The Irish reported the highest rate of across-the-board drug use of the four White ethnic populations studied. Marijuana/hashish was the most frequently used substance followed closely by alcohol. A profile of both Irish populations is shown below.

Table 8
Regular/Heavy Use of Substances for *Irish* Comparison of NCUEA and NYPS Samples

Substance	NCUEA	NYPS
Alcohol	35.7	12.4
Marijuana/Hashish	39.3	44.3
Barbituates	7.4	7.2
Amphetamines	11.1	5.2
Heroin/Opiates	7.4	5.2
Illegal Methadone	7.1	0
Inhalants	3.6	3.1
Tranquilizers/Sedatives	3.6	6.2
Hallucinogens	7.1	3.1

The NCUEA Irish sample tended to report higher usage than the NYPS sample except for marijuana/hashish, tranquilizers/sedatives and barbituates. Based on the other samples the NYPS report of current alcohol abuse of 12.4% represents some under reporting. Both samples report higher than NCUEA Total rates of use for barbituates, amphetamines and tranquilizers/sedatives. The most striking disparity between the samples is the use of illegal methadone. While 7.1% of the NCUEA sample report using illegal methadone recently, NYPS reports no respondents. This difference cannot be explained by the data available.

Americans. This population reported some of the highest rates of recent/heavy drug use in both surveys. Table 9 shows a comparison of these results.

Table 9
Regular/Heavy Use of Substances for *American* Comparison of NCUEA and NYPS

Substances	NCUEA %	NYPS %
Alcohol	36.6	26.1
Marijuana/Hashish	31.5	48.4
Barbituates	6.5	7.6
Amphetamines	3.4	5.4
Heroin/Opiates	1.9	3.8
Illegal Methadone	1.5	0
Inhalants	6.1	1.1
Tranquilizers/Sedatives	5.3	5.4
Hallucinogens	1.1	2.2

The group designated as "Americans" showed high rates of use in both alcohol and marijuana/hashish in both samples, though they were in different order. The major difference in the samples comes in the reported use of inhalants with the NCUEA being five times larger than NYPS. This reversal is due to the large number of "Americans" who appear in Southeast Baltimore where the inhalant problem is especially severe. Overall, the 18 years and younger "Americans" group reflected very high rates of barbituates, amphetamine and tranquilizer/sedative use and moderate rates of opiate use.

Italians. The Italian adolescent exhibited markedly lower rates of heavy drug use in the NCUEA sample, but only somewhat lower in the NYPS sample. In both sub-samples the rate of marijuana/hashish use was 60% higher than the use of alcohol. There were two major differences in the samples, the NCUEA group reported a 2.9% rate of tranquilizer/sedative use compared to 7.9% for NYPS, Table 10, shows a comparison of these two samples.

Table 10
Regular/Heavy Use of Substances for *Italian* Comparison of NCUEA and NYPS

Substance	NCUEA %	NYPS %
Alcohol	18.6	23.7
Marijuana/Hashish	30.0	38.2
Barbituates	4.3	7.9
Amphetamines	1.4	3.9
Heroin/Opiates	0	11.8
Illegal Methadone	2.9	2.6
Inhalants	2.9	1.3
Tranquilizers/Sedatives	2.9	7.9
Hallucinogens	1.3	1.4

Heroin use among the NYPS sample was over 2.5 times as great as the NCUEA entire white population. This was the single highest heroin/opiate rate reported in either study.

Germans. The NYPS German sample presented higher usage with all drugs except inhalants in which no usage was reported in either study. Uniquely the Germans in the NCUEA study reported as significant use in seven of the nine drug categories. While the 18 and younger population to the NYPS sample exhibited usage rates comparable to the other ethnic groups, the pattern of marijuana/hashish use being higher than alcohol holds with the German population, with barbituates, amphetamines and tranquilizers/sedatives showing the next highest rates. For German population in the NCUEA sample this profile changes when we compare the younger group with the older. Table 11 shows a comparison of the tabulations.

Table 11
Regular/Heavy Use of Substances for *German* Comparison of NCUEA and NYPS

Substance	NCUEA %	NYPS %
Alcohol	8.7	17.5
Marijuana/Hashish	13.0	48.2
Barbituates	0	4.4
Amphetamines	0	2.6
Heroin/Opiates	0	0.9
Illegal Methadone	0	1.8
Inhalants	0	0
Tranquilizers/Sedatives	0	2.6
Hallucinogens	0	0.9

In summary, both samples of 18 year old and younger adolescents show marijuana/hashish as the most used substance followed, at some distance, by alcohol. Barbituates, amphetamines and tranquilizers/sedatives were the next group of substances most often followed by inhalants. Each White ethnic group tended to follow this general pattern but there were specific differences after alcohol and marijuana hashish use.

A general pattern emerges which shows the Irish adolescents having the most serious drug use problems followed by "Americans" and Italians.

The NCUEA White/Non-White Comparison

We now turn to an examination of how six White ethnic groups compare to each other and to non-White ethnic groups in the NCUEA study. The NCUEA sample is subdivided into 10 specific ethnic groups; the table that follows shows the distribution of each ethnic group in two broad age categories: 18 and younger and 19 and older.

The data shown in Table 12 represents those respondents who provided information on all the characteristics which we will analyze in this section.

Table 12
Distribution of NCUEA Total Sample by Ethnic Group, by Age

Ethnic Group	18 or Younger	19 or Older	Total	18 or Younger	19 or Older	Total
White						
White Different	71	25	96	73.9%	26.1%	8.3
White Same	195	56	251	77.7	22.3	21.3
Polish	170	32	203	84.2	15.8	17.6
Italian	72	26	98	73.5	26.5	8.5
Irish	29	17	46	63.0	37.0	4.0
German	23	20	43	53.5	46.5	3.7
Non-White or Other						
Black	161	16	177	91.0	9.0	15.4
Hispanic	62	8	70	88.6	11.4	6.2
Native American	67	16	83	80.7	19.3	7.2
Mixed Racial	64	20	84	76.2	23.8	7.3
Total	915	236	1151	79.5	20.5	100.0

The 19 and above (older) population represents approximately one fifth of the total sample and has an average age of approximately 20 years; the average age of the 18 and younger group was just over 16 years. The distribution of the age groups among ethnic samples did not follow any specific pattern. The 19 or older group ranges from a low of 9.0% (Black) to a high of 46.5% (German) as a percentage of the population. To allow for this difference, the analysis of use by each ethnic group or aggregate ethnic groups, will be confined to a comparison between the two age groups unless the age distributions are statistically comparable.

Table 13 shows the comparison of the regular/heavy current use of substances for the total NCUEA population, by age group.

Table 13
Regular/Heavy Current Use of Drugs by Age

Substance	18 or under	19 or over	Ratio
Alcohol	20.8%	37.0%	1.78
Marijuana	28.7	35.9	1.25
Barbituates	5.9	12.3	2.08
Amphetamines	3.6	10.1	2.81
Heroin	2.5	9.1	3.64
Illegal Methadone	2.5	6.8	2.72
Inhalants	4.7	5.0	1.06
Tranquilizers	4.0	7.8	1.95
Hallucinogens	2.9	4.4	1.52

It is not surprising that higher rates of use of each substance are reported by the older age groups; what is striking is the differential effect age has on the use of each drug. In descending magnitude, increased age seems to directly affect the regular use of heroin (3.64), amphetamines (2.81), illegal methadone (2.72), barbituates (2.08), and tranquilizers (1.95). Age seems to have lesser effect on the regular use of alcohol (1.79) and hallucinogens (1.52) and almost no effect on marijuana (1.25) and inhalants (1.06). This difference is probably due to the relatively high rates of use of these latter two substances at an earlier age. This finding has major implications for the establishment of early prevention and intervention programs dealing with specific substance abuse.

The next step in our analysis was to compare the effect of age on patterns of drug use within broad categories of ethnic groups. We designated three such categories: White (White Same, White Different, Polish, Italian, Irish, German); Non-White (Black, Hispanic, Native American) and Mixed Racially. Table 14 shows the ratio of regular/heavy drug usage for the total sample and each of the aggregate ethnic groups.

Table 14
Ratio of Percent of Regular/Heavy Substance Use
18 or Younger Compared to 19 and Over by Aggregate Ethnic Group

Substance	Total	White	Non-White	Racially Mixed
Alcohol	1.78	1.62	1.65	2.11
Marijuana	1.25	1.22	1.04	1.35
Barbituates	2.08	3.00	2.17	2.69
Amphetamines	2.81	4.02	1.59	3.34
Heroin	3.64	5.54	3.91	4.02
Illegal Methadone	2.72	3.14	3.26	2.68
Inhalants	1.06	1.15	1.11	1.20
Tranquilizers	1.95	2.16	3.85	2.71
Hallucinogens	1.52	3.85	1.20	0.94

From this table we can see that age has a different effect on the aggregate ethnic groups. White ethnics' use of barbituates, amphetamines, heroin and hallucinogens accelerates much faster than other ethnic aggregates after 18. To investigate this further, we compared the

regular-heavy current use of specific substance for each of the specific ethnic groups. These data are presented in Table 15.

A review of this comprehensive table by substance shows some interesting patterns of heavy usage.

Alcohol. The heaviest consumers of alcohol of the younger age groups are the Irish (35.7%), White Same (33.8%), Native American (28.1%) and Mixed Racially (25.8%). If we look at the older group we have the Irish (56.3%), Mixed Racially (54.5%), Germans (52.4%), and Native American (40.0%). The most startling change is in the Germans from 8.7% to 52.4%, a ratio of 6.02.

Marijuana. The pattern of heavy use of marijuana is similar to that of alcohol for the 18 and younger groups except for the relatively lower use by the Irish: White Same (53.5%), Native American (41.3%), Mixed Racially (38.7%) and Irish (39.3%). Again the 19 and older group included the addition of German (52.4%), as well as Mixed Racially (52.2%), White Different (42.2%) and Italians (39.3%). Use among White Same, Irish and Hispanics decreases.

Barbituates. The use pattern for barbituates in the adolescent population shows Native American (11.1%) and Irish to be distinctively higher than the others. The patterns in the older group shows continued patterns of use by Mixed Racially (26.1%) and Native American (15.8%) and the emergence of Blacks (19.0%), Italians (14.3% and Germans (14.3%).

Amphetamines. In the younger sample the Irish and Native American (11.1%) are both heavy users. The older sample shows Mixed Racially (21.7%), Italian (17.9%), Black (14.3%) and Irish (12.5%) and White Same (12.0%) as the major users. Especially notable is the increase in the White Different group from 0.5% to 10.5%, the Italian increase from 1.4% to 17.9%, the Mixed Racially increase from 6.5% to 21.7% and the Black increase from 3.8% to 14.3%. In this sample Native American *decreased* from 11.1% to 5.6%.

Heroin. The regular/heavy use of heroin was reported by 2.5% of the 18 or under total sample but was especially high among Native Americans (9.7%) and Irish (7.4%). The rates of use escalate alarmingly in the 19 and over group (9.1%) with Blacks (18.8%), Germans (14.3%), Hispanics (11.1%) and Native American (10.5%) reporting excessively high rates. The greatest rate of increase occurred within the German, Blacks and Polish samples.

Illegal Methadone. This substance showed one of the lowest overall rates of regular/heavy use (2.5%) for the 18 and younger population but

Table 15
Regular/Heavy Current Use of Drugs
by Ethnic Groups by Age

Substance	Total	White Same	White Diff	Polish	Italian	Irish	German	Total White	Black	Hispanic	Native American	Total Non-White	Mixed Racially
Alcohol													
18 or under	20.8	33.8	22.2	17.5	18.6	25.7	8.7	21.9	13.3	24.2	28.1	19.0	25.8
Over 18	37.0	37.5	34.5	30.3	28.6	56.3	52.4	35.6	33.3	10.0	40.0	31.4	54.5
Marijuana													
18 or under	28.7	56.3	30.6	22.2	30.0	39.3	13.0	30.9	19.5	29.5	41.3	26.4	38.7
Over 18	35.9	33.3	42.4	21.9	39.3	37.5	52.4	37.8	28.6	10.0	25.0	27.5	52.2
Barbiturates													
18 or under	5.9	5.7	4.1	2.9	4.3	7.4	0.0	3.9	5.1	4.8	11.1	6.3	9.7
Over 18	12.3	8.0	10.5	12.5	14.3	12.5	14.3	11.7	19.0	0.0	15.8	13.7	26.1
Amphetamines													
18 or under	3.6	5.6	0.5	2.3	1.4	11.1	0.0	2.3	3.8	1.6	11.1	4.9	6.5
Over 18	10.1	12.0	10.5	0.0	17.9	12.5	4.8	9.4	14.3	0.0	5.6	7.8	21.7
Heroin													
18 or under	2.5	2.8	1.0	0.6	0.0	7.4	0.0	1.3	2.5	0.0	5.6	3.5	6.5
Over 18	9.1	4.0	3.5	6.1	7.1	18.8	14.3	7.2	19.0	11.1	10.5	13.7	26.1
Illegal Methadone													
18 or under	2.5	2.8	0.5	0.6	2.9	7.1	0.0	1.4	2.5	0.0	12.7	4.2	6.5
Over 18	6.8	8.0	3.5	3.0	0.0	11.8	4.8	4.4	19.0	0.0	15.0	13.7	17.4
Inhalants													
18 or under	4.7	7.0	3.6	2.3	2.9	3.6	0.0	3.4	3.2	4.8	10.9	5.3	11.3
Over 18	5.0	4.0	5.4	0.0	0.0	11.8	4.8	3.9	14.3	0.0	15.0	5.9	13.6
Tranquilizers													
18 or under	4.0	4.2	3.6	2.3	2.9	3.6	0.0	3.1	1.3	1.6	15.6	4.6	4.8
Over 18	7.8	8.0	9.1	3.1	3.6	11.8	4.8	6.7	23.8	0.0	20.0	17.7	13.0
Hallucinogens													
18 or under	2.9	1.4	1.0	1.2	1.4	7.1	0.0	1.3	2.6	3.2	12.5	4.9	4.8
							4.8	5.0	14.3	0.0	0.0	5.9	4.5

did show high rates in the Native American (12.7%), Irish (7.1%) and Mixed Racially (6.5%) groups. For the older group, Blacks (19.0%) are added to Mixed Racially (17.4%) and Irish (11.8%). Note that in neither age group did Hispanics use illegal methadone and the rate for Italians decreased from 2.9% to 0.

Inhalants. The rate of change between the age groups for inhalant abuse was the lowest recorded, going from 4.7% to 5.0% but there were striking patterns within specific ethnic groups. Mixed Racially (11.3%), Native American (10.9%) and White Same (7.0%) were the highest ethnic group users among the young while Black (14.3%), Mixed Racially (13.6%) and Irish (11.8%) led the older group. Inhalants, which are usually considered to be drugs used by the young showed the greatest number of reported decreases among the White Same, Polish, Italian, Hispanic and Native American subsamples.

Tranquilizers. For the younger sample, tranquilizers showed high rates of use within the Native American (15.6%) subsample. In the older group these substances were used by Blacks (23.8%), Native American (20.0%), Mixed Racially (13.0%) and Irish (11.8%). Only Hispanics reported a decrease in usage between the age groups—from 1.6% to 0.

Hallucinogens. The use of hallucinogens among adolescent Native American (12.5%) was followed by the Irish (7.1%) and Mixed Racially (4.8%). All other ethnic group swere considered lower. In the 19 and over group the rate of use among Native American drops to zero while Blacks (14.3%), Irish (11.8%) and White Same (8.0%) report high usage rates.

The descriptive data provided above indicates that drug usage patterns differ among specific ethnic groups in the same age cohort and also change within the same ethnic group at different ages. To cast this observation in a more concise manner it would be useful to look at the intensity of regular/heavy drug use for each ethnic group. Table 16 shows the number of times the specific ethnic group drug use was statistically higher than that of the entire sample over the nine substances investigated.

Table 16
Number of Times Regular/Heavy Use Exceeds Total Population Use by Age Group

Ethnic Group	18 and younger		19 and over	
White Same	7/9	78%	3/9	33%
White Different	2/9	22%	4/9	44%
Polish	0/9	0	0/9	0
Italian	2/9	22%	3/9	33%
Irish	7/9	78%	8/9	89%
German	0/9	0	4/9	44%
Black	0/9	0	7/9	78%
Hispanic	2/9	22%	1/9	11%
Native American	9/9	100%	5/9	56%
Mixed Racially	9/9	100%	8/9	89%

From Table 16 we can see that Mixed Racially respondents are the most intense users of drugs regardless of age, followed by Native American and the Irish. Within the entire sample, the least intense users of drugs are the Polish, Hispanics and Italians. The Germans and the Blacks exhibit a low profile in the younger category but a greater intensity in the older group. While it is obvious that these results cannot be extended to a general policy regarding program design, there are clear implications that service practitioners must take into account both age and ethnicity when developing programs.

Other Measures of Drug Use Among Ethnic Groups

When we consider the 18 and younger sample, the major indicators of the prevalence of drug use showed sharply different patterns among the NCUEA ethnic groups. Our data shows that drug abuse among the White ethnic groups, taken as a whole, is as high as that among non-White and that some specific groups, notably the Irish and White Same have rates of serious drug use which far exceed other White and non-White ethnic groups. Our evidence indicates that Native American adolescents are the heaviest users of drugs and that Native American females start taking drugs at an earlier age than all other females.

The measures used to assess the extent of drug abuse in specific ethnic groups include:

- Reported use by friends
- Age of first use
- Index of recent use
- Regular/heavy use by sex

Reported Use by Friends. The reported use of drugs by friends has often been used as a proxy variable to determine the extent of drug abuse within a specific population. In Table 17 we present the information relative to the entire population and each of the 10 ethnic groups.

As might be expected, the pattern for the general population showed marijuana and alchol as having the highest rates of use, followed by amphetamines and barbituates and then opiates, inhalants, and hallucinogens. The pattern within each of the ethnic groups differs greatly in regard to the proportion of the sample reporting friends' use and specific drugs used. The White Same and Native American populations consistently report rates of use which are substantially higher than the total sample in all drug categories while the Polish and Black populations were always below. The White Same sub-sample showed the highest reported rate of alcohol, marijuana and inhalant use while the Native American subsample was highest in barbiturates, amphetamines, opiates and hallucinogens. The Irish adolescents, who had shown high rates of personal use, reported use rates among friends which approximated the sample.

Age of First Use. The data in the first column of Table 18 presents the average age of first use of the total population for the nine substances which we are studying. When taken in a chronological order, there appears to be a definite progression in substance use; inhalants are first (12.80 years old) followed by alcohol and marijuana. (Surprisingly the use of heroin is reported at a younger age than marijuana but this is probably caused by the low average reported by the Native American adoles-

Table 17
Reported Substance Use by Friends by Ethnic Group

Substance	Total Population	White Same	White Diff	Polish	Italian	Irish	German	Black	Hispanic	Native American	Mixed Racially
Alcohol	64.5%	79.5%	68.0%	61.0%	67.3%	65.3%	71.0%	53.6%	63.7%	71.3%	61.7%
Marijuana	64.6	81.1	68.8	53.7	63.1	62.1	65.2	54.3	69.4	76.4	73.1
Barbiturates	30.6	41.7	36.0	18.6	31.9	33.1	30.4	17.6	35.2	49.9	39.7
Amphetamines	25.2	42.5	24.2	13.1	31.9	30.3	24.3	17.1	28.1	45.1	28.1
Opiates	14.0	20.3	14.2	5.5	18.3	17.2	13.0	9.9	13.5	25.4	22.5
Inhalants	19.1	35.8	22.5	6.4	16.1	16.6	23.5	11.3	19.0	34.0	30.6
Hallucinogens	17.4	29.5	17.5	8.8	19.7	26.9	7.4	11.6	13.9	34.0	20.6

Table 18
Age of First Use of Substance

			Males					Females			
			Youngest		Oldest			Youngest		Oldest	
Substance	Total Population	Total Average Age	Ethnic Group	Average Age	Ethnic Group	Average Age	Total Average Age	Ethnic Group	Average Age	Ethnic Group	Average Age
Alcohol	12.95	12.64	German	11.20	Hispan	13.50	13.33	NA	12.33	German	14.55
Marijuana	13.50	13.26	NA	12.77	Black	13.78	13.81	NA	13.00	Polish	14.63
Barbiturates	13.87	13.74	Italian	13.25	WS	14.27	14.07	NA	12.25	Hispan	14.60
Amphetamines	14.13	14.01	Italian	13.54	Hispan	15.00	14.32	NA	12.36	Polish	15.10
Heroin	13.14	13.08	NA	9.00	Black	14.33	13.29	---	---	---	---
Illegal Methadone	13.66	13.55	NA	12.40	Black	15.00	13.88	---	---	---	---
Inhalants	12.80	12.58	Irish	11.80	Polish	13.00	13.18	NA	11.42	WD	14.64
Tranquilizers	13.56	13.40	NA	11.25	Hispan	16.00	13.80	NA	10.71	WD	14.50
Hallucinogens	13.61	13.58	NA	11.86	MR	14.50	13.70	NA	10.40	WD	15.17

cents). Tranquilizers, hallucinogens, illegal methadone, barbituates, and amphetamines all follow within a short time-frame. It is interesting to note that the average ages span the years from 13 to 14, the first "teen" year and the time when most adolescents go from grade school to junior high. This finding has major implications for the targeting of prevention and intervention programs.

The balance of the data in Table 18 focuses on determining the youngest and oldest average age of first use by each sex and ethnic group. From the broad aggregation we can see the Native American youth predominant in the earliest use of substances (especially among the females), while the oldest first users are distributed among many ethnic groups.

Comparing columns 2 and 3, we see that males tend to report an age of first use which is 3 to 6 months earlier than females for all substances but both groups tend to follow the general sequence reported for the total population. In addition to the Native American adolescents, early users among males are represented by Italians, German, and Irish youths. The later users among males tend to be Hispanic and Black with a lag time of 6 months to one year from the first users.

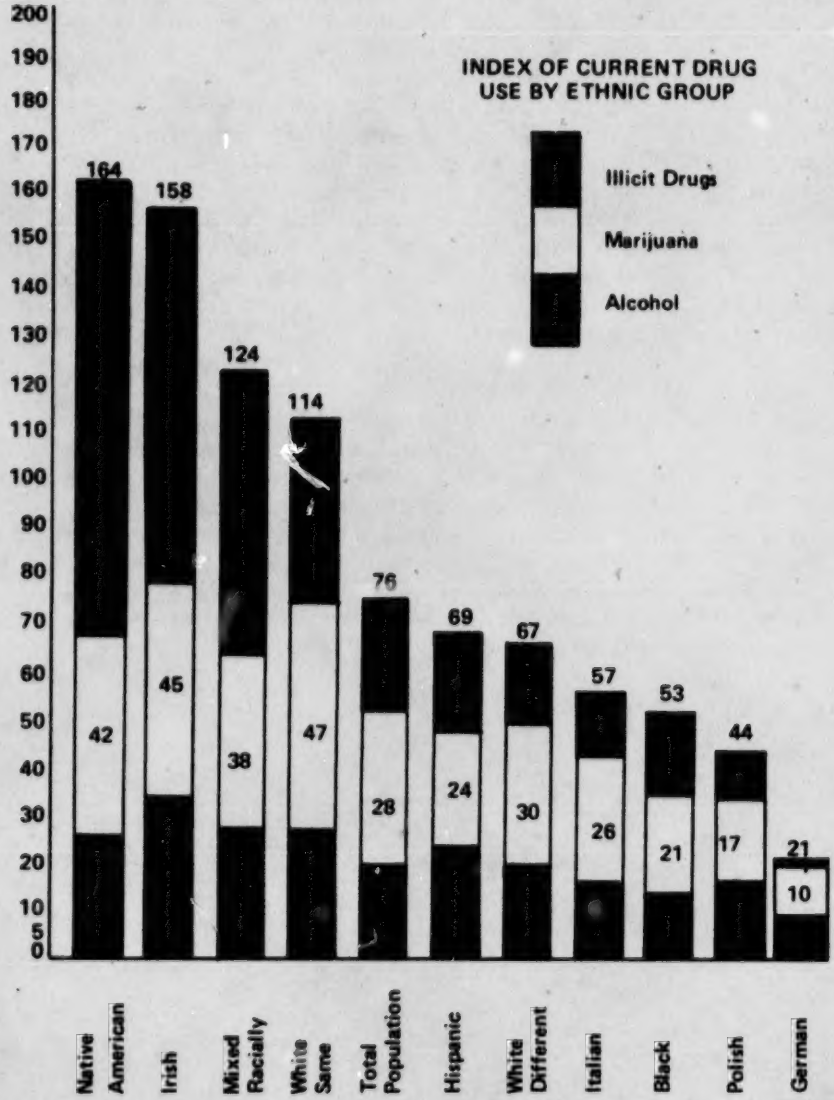
The reported first age among Native American females is alarming because of its consistency across all substances. This, coupled with the reported early experimentation among the males points to a major problem of drug use among the inner-city Native American populations. The late users among the females are concentrated in White Different, Polish Hispanic and Germans—a pattern similar to males.

Index of Recent Use. In Table 15 we presented the percent of ethnic adolescents (18 or younger) who are considered regular/heavy recent users of specific drugs. In Chart 1 we calculate the index of drug use per 100 person days (described earlier) for this same population. In this chart we also show an index of illicit drug use which is a composite of all the substances in the study except alcohol and marijuana. The Overall Index of Drug Use which includes alcohol and marijuana is also shown.

One of the most startling figures in the tables is the extremely high rate of illicit drug use within the Native American population—an index of 96 per 100 person days. This rate is over 20% greater than the next highest rate (Irish: 79) and 3.5 times the sample average (28). The other populations exhibiting a high index are the Mixed Racially and White Same; the single highest rate of any substance abuse is marijuana among the White Same (47). In a hierarchy of use the Germans represent the lowest usage pattern while the Native Americans represent the highest; the Irish are the highest White ethnic group.

Regular/Heavy Use by Sex. Rather than focus on the index of drug use described previously, this section will explore only those individuals who show a significant drug problem. The regular abuse of any of the nine

Chart 1
Index of Recent Substance Use by Ethnic Group



substances being studied in this report gives a clear sign of severe pathology (19,33). In Table 19, the data reflect these rates of use for each ethnic group by sex of the respondents. The reported rate of drug abuse among males is substantially higher than among females; however, there are some instances where females of one ethnic group are higher than males of another or, as in the case with the Native Americans, even higher than males in their own group for specific drugs.

For the total population, the heavy use of alcohol and marijuana among males is 1.7 times greater than among females. The greatest difference in alcohol use is between the male and female Irish while the most similarity occurs in White Same (with both rates being well above average). Marijuana use follows a different pattern—again large discrepancies among the Irish but convergence among the other populations, i.e., the Native American group where the female rate exceeds the male. These data indicates that marijuana is becoming the drug of choice for both males and females and that its use is not as significant a sex identifier as alcohol or other drugs.

In summary, we see from the measurements employed that there is considerable variability in adolescent drug use based on ethnicity and sex. The Native American subsample exhibited early use of substances, a higher percentage of friends reported use and alarming rates of current use. Contrary to most research, the use among females surpassed that of males in some instances. When we concentrate on the White ethnic populations, there are wide varieties of use evidenced. While the Polish usually exhibit rates well below the populations, the Irish were always among the highest.

Table 19
Regular/Heavy Recent Drug Use
by Ethnic Group by Sex

Substance	Sex	Total	White Same	White Diff	Polish	Italian	Irish	German	Black	Hispanic	Native American	Mixed Racially
Alcohol	M	21.3%	36.6%	28.8%	24.1%	26.3%	52.9%	12.5%	16.5%	37.5%	30.3%	34.2%
	F	12.4	31.0	13.8	10.0	10.3	9.1	7.1	10.3	13.5	21.4	9.5
Marijuana	M	35.0	65.9	35.9	28.7	36.8	58.8	12.5	20.2	47.8	33.3	39.5
	F	20.5	41.4	25.0	13.8	20.7	9.1	7.1	20.0	16.2	50.0	28.6
Barbiturates	M	8.1	10.0	5.8	3.4	7.9	6.3	0.0	7.1	4.2	12.1	7.9
	F	2.6	0.0	2.5	1.3	0.0	9.1	0.0	2.9	5.4	7.4	0.0
Amphetamines	M	3.5	7.3	1.0	1.1	2.6	12.5	0.0	4.8	0.0	6.1	2.6
	F	2.4	3.4	0.0	2.5	0.0	9.1	0.0	2.9	0.0	14.8	0.0
Heroin	M	3.0	4.9	1.9	1.1	0.0	6.3	0.0	3.6	4.2	6.3	5.3
	F	1.2	0.0	0.0	0.0	0.0	9.1	0.0	1.4	0.0	7.4	0.0
Illegal Methadone	M	3.2	4.9	1.0	1.1	2.6	5.6	0.0	4.7	0.0	6.1	5.1
	F	1.0	0.0	0.0	0.0	0.0	9.1	0.0	0.0	0.0	14.8	0.0
Inhalants	M	6.0	12.2	5.8	4.6	2.6	5.9	0.0	4.7	0.0	9.1	7.9
	F	2.2	0.0	1.3	0.0	3.4	0.0	0.0	1.5	5.4	10.7	5.0
Tranquilizers	M	4.2	7.3	6.7	2.3	2.6	5.9	0.0	0.0	4.2	12.1	5.1
	F	2.3	0.0	0.0	1.3	0.0	0.0	0.0	3.0	0.0	14.3	0.0
Hallucinogens	M	3.3	2.4	1.9	2.3	5.3	5.9	0.0	3.6	4.2	9.1	2.6
	F	1.2	0.0	0.0	0.0	3.4	9.1	0.0	1.5	0.0	10.7	0.0

Correlation of Perceptions of Parents to Drug Use Patterns

Another analysis of the NCUEA sample focused on a comparison between users and non-users perception of parents. This analysis was performed using the entire NCUEA sample for each ethnic group by sex of respondent for both fathers and mothers. Fathers and mothers were rated on 10 traits, 5 positive and 5 negative. Four tables present the results of this complex analysis. (20A-20D)

Each respondent was asked to scale each of the parents for 10 individual traits. We then cmopared recent drug regular users with non-users in their perception of parents to see if there were any statistical differences in the scale. For ease of presentation we used alcohol, marijuana, and illicit drugs as our substance categories. The chart shows the number of traits for which there were significant statistical differences. For instance, a 2 means that out of five traits—either positive or negative—there were two which regular users and non-users scaled differently. Rather than delve into great detail concerning the interpretation of these tables, we will draw some general conclusions here.

Polish and Hispanic users and non-users, regardless of the drug used, exhibited no sense of alientation from either parent except in some minor instances. (A major distinction occurs if there is a statistically significant difference on three of the five traits.) These were the only two groups which exhibited this pattern throughout the tables.

German, male, marijuana users felt less positive toward their fathers than non-users and indicated a possibility of alientation from their mother. When German males did feel alientated from their mother, this correlated with illicit drug use.

The Irish respondents, who exhibited the higher usage rates among the White adolescents, did not tend to exhibit any negative perceptions of their parents except for male alcohol users who saw their fathers negatively.

Italian users, on the other hand, had very complex reactions to each parent. Both male and female Italian alcohol users felt less positively about their mothers than non-users. In addition, Italian male illicit drug users felt less positively than non-users about their mothers and fathers; Italian female marijuana users felt less positively about their fathers than non-users.

The Black alcohol and illicit drug users, both male and female, feel less positively about each parent than the non-users. Both male and female marijuana users are more distant from their mother compared to the non-users, but are not alienated from their fathers.

Table 20A
Perception of Differences in Perceived Characteristics between Users and Nonusers Male/Father

Male Perception of Father	German	Irish	Italian	Polish	White Same	White Diff	Black	Native American	Hispanic
Alcohol									
5 Positive Traits	1	0	0	0	1	1	3	0	0
5 Negative Traits	0	3	1	0	0	0	0	0	0
Marijuana									
5 Positive Traits	3	1	0	0	3	0	2	0	0
5 Negative Traits	1	1	0	0	1	0	0	1	1
Illicit Drugs									
5 Positive Traits	0	1	4	2	5	1	5	0	0
5 Negative Traits	0	0	0	0	1	1	0	0	1

Table 20B
Perception of Differences in Perceived Characteristics between Users and Nonusers Male/Mother

Male Perception of Mother									
Alcohol									
5 Positive Traits	0	0	2	0	0	0	3	0	1
5 Negative Traits	0	0	2	1	1	1	0	0	0
Marijuana									
5 Positive Traits	2	0	2	1	1	1	4	0	1
5 Negative Traits	0	0	0	0	3	2	0	2	0
Illicit Drugs									
5 Positive Traits	4	1	3	0	0	3	4	0	1
5 Negative Traits	3	0	0	0	0	0	0	1	0

Table 20C

Perception of Differences in Perceived Characteristics between Users and Nonusers Female/Father

Female Perception of Father	German	Irish	Italian	Polish	White Same	White Diff	Black	Native American	Hispanic
Alcohol									
5 Positive Traits	0	0	2	1	2	0	3	0	0
5 Negative Traits	0	0	2	0	0	0	1	0	0
Marijuana									
5 Positive Traits	1	1	3	1	3	0	0	1	0
5 Negative Traits	2	1	2	0	1	0	0	3	0
Illicit Drugs									
5 Positive Traits	1	0	1	1	0	1	5	2	2
5 Negative Traits	0	0	2	0	1	0	0	5	1

Table 20D

Perception of Differences in Perceived Characteristics between Users and Nonusers Female/Mother

Female Perception of Mother									
Alcohol									
5 Positive Traits	2	2	3	0	0	0	5	2	0
5 Negative Traits	1	1	1	0	1	1	0	0	0
Marijuana									
5 Positive Traits	0	0	2	0	1	1	3	1	0
5 Negative Traits	1	0	1	0	0	1	0	2	0
Illicit Drugs									
5 Positive Traits	0	0	0	0	1	3	4	4	1
5 Negative Traits	0	0	1	0	1	0	1	4	0

The Native American females, one of the heaviest using groups, who takes illicit drugs feels alienated from both their mothers and their fathers compared to their non-using counterparts.

Thus, we see from this data that ethnic processes do have a tremendous bearing on how users related to their parents. While a Black or Native American user may feel a sense of distance form one or the other parent, Polish and Hispanics do not feel it; or if they do feel it, they do not articulate it. These differing patterns imply that major prevention and treatment strategies must be reviewed, and probably modified, if they are to be effective among specific White ethnic groups.

The Importance of Ethnicity

Ethnic/cultural socilization processes must be recognized as having an important impact on the individual's identity formation and should be understood by treatment providers. Southern European, Eastern European, Catholic neighborhoods each have a distinct life history with their own customs and mores. For instance, the persistence of a language other than English being used in households indicates a value system different from the larger society. These distinct life histories, customs, and mores have an, as yet unmeasured, effect on behavior, mental health processes, drug usage, drug prevention and treatment success.

Our experience shows that ethnic neighborhoods tend to be very tightly structured and closed to outside intervention in dealing with local issues. In many cases drug treatment programs are viewed as being offered by outsiders who have no appreciation of ethnicity and who operate programs in a confusing manner to those who have need for drug treatment services. In the course of our work, many community residents have asserted that services are lacking in accountability and that delivery systems do not provide for attention to prolonged needs or for a comprehensive analysis of the client's problems.

Such judgments are made more complex because we do not have a handle on the interdependencies existing between ethnicity, social class and well-being. Although important work has been carried out linking service delivery to neighborhoods, little consideration has been given to neighborhoods which reflect a multi-ethnic population or a Southern European, Eastern European or Catholic ethnic population.

Complicating this situation is the fact that too often the local prevention, intervention and treatment personnel ignore the existing neighborhood infrastructure as they are trying to serve local needs. (21) In many cases the result is that programs are not identified by residents as neighborhood resources, the programs bring "outsiders" in for treatment, and friction develops between the program and the neighborhood residents. In several instances this friction has forced programs to close down or substantially curtail their operations.

Another body of literature shows the importance of neighborhood-based networks. It is imperative to know how people solve their problems and cope with crises when they are outside the system of professional agencies. Myers and Bean (16) in their study of social class and mental illness point out that for those in treatment, the effectiveness of the help received will depend on the social support or lack of support in a person's neighborhood. The importance neighborhood-based cultural or organizational networks have on assisting professionals to work with the physically and mentally ill has been noted by several scholars. Slater (35), Glazer (9), Warren (39), Litwok (23) and Breton (2) present the issue in a similar way. For instance, Glazer (9) notes that a significant contribution to the present crises in public social

policy and service delivery is due to the breakdown of "traditional" organizations and ways of dealing with problems. Breton (2), analyzing the issue from the ethnic dimension, points out that greater attention should be given to the social organization (fraternal organizations, ethnic clubs, etc.) of ethnic communities, particularly to the wide variation which exists among them.

Bypassing existing neighborhood-based networks in establishing programs makes it more difficult for people to utilize professional expertise. (6) Therefore, important questions relate to how people—who are not part of neighborhood-based delivery systems—cope with their problems. What neighborhood-based formal and informal networks of service delivery are being used? What orientation of the formal delivery systems are necessary so that the social organization within the neighborhood is strengthened? Will a delivery system which is culturally compatible with a neighborhood increase utilization and reach people in need.

An Indication of the Treatment Response

In the second year of the NCUEA study, we evaluated the response of the existing service delivery system to meet the needs of the White ethnic adolescents. In looking at existing data bases and the CODAP system, we found that little information was available on a Census Tract basis and even less was available by specific White ethnic group. With the cooperation of the Wayne County Department of Substance Abuse Services, we were able to obtain data on a Census Tract basis for heavily ethnic communities. Using the racial category of White as a substitute for White ethnic, we analyzed treatment outcome data and found:

- While Whites made up 35% of total admissions, they accounted for 52% terminations before 30 days.
- Fifty-eight percent of the Whites were terminated because they either refused or discontinued services; the rate was 40% among Blacks.
- Thirty-four percent of Whites were considered detoxified when they left treatment compared to 43% of Blacks.
- While 27% of Blacks were reported using drugs at time of termination, the rate was 39% for Whites.

It may be construed from this crude data that the existing system may not be serving the need of White ethnic adolescents.

This observation led to a more extensive evaluation study of the specific treatment facilities, both drug and non-drug, which serve the four communities in this study. We conducted interviews with program administrators, counselors, neighborhood residents, community leaders, and clients and found:

- There are few programs which deal exclusively with adolescents.
- There are no programs which make distinctions about special programs for White ethnics.
- Adolescents feel uncomfortable in programs with older addicts.
- White ethnic youths find it easier to relate to counselors who are sensitive to ethnic clients' identity.
- Ethnic heritage studies can be useful in developing positive self-images among troubled youth.

Some Considerations Regarding Prevention, Intervention and Treatment

The data presented in this publication indicate that a drug abuse problem does exist among White ethnic adolescents and that there are few treatment mechanisms to deal with it. What possibilities can be entertained? While we certainly do not advocate that only Black counselors should treat Black clients and Polish treat Polish, etc., we do think it is important that drug abuse workers have a special sensitivity to the socialization processes of the specific ethnic group(s) which they are serving. One step which may help is establishing more community involvement in the operation of programs because effective institutions begin with the community which those institutions are to serve. We propose that it is only through community development and sponsorship that programs can effectively reach a local target population. Especially in the emotionally charged area of drug treatment, the support, assistance, control and cooperation of community residents is essential. The literature is filled with cases of programs which have failed because of adamant opposition by communities.

As the human service delivery system has evolved, community leaders are now demanding a greater voice in the development and implementation of programs. No longer awed by professional and para-professional workers, people in local communities are asking very concrete questions as to how service programs will affect their neighborhoods and their lives. In many cases they are not receiving satisfactory answers. Today, people in the human service delivery system find themselves as responsible to the local communities as they are to funding sources.

Based on our findings, we propose the treatment program to be based on the following operating factors:

1. *Different approaches to prevention, intervention and treatment are required for each ethnic group.* Research (11, 3) concerning inner-city neighborhoods have shown that while socio-economic characteristics may be similar across ethnic groups, attitudes toward the social environment may differ markedly. The NCUEA believes that any program must take these social, ethnic and cultural factors into account if it wants to provide appropriate services to a broad range of clients. To be sure, there are some factors which are common to all ethnic groups: distrust of certain governmental institutions, a conflict between lower and upper classes, a desire for upward mobility, etc. and these can be used as the basis for building community-based programs.

2. *Prevention and treatment programs must have strong community participation and support to be effective.* Many programs are aimed at parents, children and/or schools but very few function through the other

important community institutions such as churches, community development corporations, neighborhood councils, food cooperatives and even community-based credit unions. The NCUEA believes that for any program to have a significant impact on a local area, there must be community planning, implementation and control.

In response to differential data such as presented here, decision makers at many levels of government have recognized the desirability of increased local control of such services as health care, schools and mental health services. Explicit in the development of the block grant concept was the desire for local groups to determine, within prescribed guidelines, how money was to be spent for services. While NIDA requires that community support for programs be demonstrated before funding is approved, there have been few projects which have actually had extensive community involvement in the planning and development stage or direct community control of the delivery of services.

Thus, in the models we envision, prevention and treatment services will be delivered by one primary organization under direct community control but it will involve many of the institutions inthe area. Prevention and treatment efforts would be the responsibility of each of an identifiable community group but would also include the effort of schools, police precincts, housing corporations, libraries, etc. The idea is to make the efforts well known enough to be considered integrated intc everyday community life.

3. *Current prevention and treatment programs conducted by agencies have little understanding of local parental and/or community processes.* In the four neighborhoods identified, many residents expressed their concern about the process of the ongoing prevention and treatment programs. Their primary disappointment stems from the lack of contact between the program representatives and parents. For instance, neighborhood residents have told us that they felt that the programs are geared to give information to the school children but keep the parents in the dark. As a solution to this, prevention agency representatives could be incorporated into community-based programs giving them more interaction with parents.

For any program to be relevant to a client, the staff must have an understanding of the value system the client derives from both the family and the community. In order to determine those external values which agree with the person's personal values and which conflict, an understanding of the person, the family and the community is necesary.

One may conjecture, based upon the data presented, that the community value system may be a cause of drug using behavior. Acceptance of drinking at an early age, an attitude of life as being futile, an inordinate amount of religious and/or social pressure to behave in a certain way, may each eventually contribute to an individual's use of drugs. It is only by examining the potential impact of these values and pressures and the concommitant community process of condemning or condoning indi-

vidual actions, that a service provider can fully identify motivational factors. By allowing communities, with the assistance of qualified staff, to develop and implement prevention, intervention and treatment efforts the value system which affects the individual will be taken into account.

According to the NIDA Manpower and Training Strategy 1977 (27), prevention and treatment manpower consists of:

- Persons employed in drug abuse prevention programs.
- Persons coordinating drug abuse prevention activities.
- Persons providing drug abuse prevention services within the context of a broader program or activity not expressly identified with drug abuse.

The training of prevention workers receives the second highest priority (after treatment workers) in the 1977 MTS, with special emphasis to be placed on workers in Community/Alternative Programs.

Similar thinking has been articulated by Glenn and Warner (10) in the *Development Approach to Preventing Problem Dependencies* which describes the predicament of young people. Tremendous technological advancement and a meteoric population shift to urban centers have dramatically changed the lifestyle which, in previous generations, accounted for the personal development of the child. Urban systems fragment and make this development—which resulted primarily from personal family interaction—difficult at best and mediates against it under most circumstances. The result is that almost one third of all adults over 18 are receiving some sort of mental health services.

The solution lies in enabling those developmental processes to take place by providing specifically for them. "Drug education must go beyond facts of illicit drugs and prepare persons to be *areful* and sophisticated users of licit substances, capable of *making good judgments* and thereby avoiding crisis, both medical and legal.

> At the same time, such educational activities must be supported by primary prevention activities that focus upon attitudes, values and developmental characteristics of the individual. Briefly stated, primary prevention consists of activities in the home, school and other institutional settings, peer group and community, that provide opportunities and support for the developmental goals outlined. . ."

Glenn and Warner (10) suggest that traditional community structures—churches, youth programs, families—adapt and enable themselves to work toward this type of primary prevention with their young people. For example, program directors might initiate "shadow leadership" in youth programs where the young hold the responsibility and adults stay in the shadow available to keep things on the course; "Family Home Evening" programs in which families set aside one night a week for discussion, recreation, learning and each member may have an opportunity to feel

his or her importance within the group; and existing people in community groups might gain a better understanding of the human developmental process with the help of mental health professionals so that they can incorporate approaches to these progresses in existing programs.

An innovative program, the Group School, in Cambridge, Massachusetts, speaks to developmental and cultural issues. (12) A curriculum has been carefully developed for working-class children to focus on the nature and importance of their own neighborhoods, their specific heritage, and their cultural background. A particular strength of this program is that it encourages young people to become curious about their backgrounds, which the individuals may have thought shameful in the context of the larger society, as a first step in developing a sense of self. Furthermore, it assumes that there will be a diversity of cultural backgrounds among the students, so it deals with working-class communities within a range of personal differences while simultaneously taking into account differences which students see between themselves and their parents. Thus, the curriculum design works to develop both self-awareness and an awareness of the similarities and differences of others.

That both goals be achieved is most important. The development of ethnic pride as a part of one's identity should broaden and help bring perspective, not narrow or encourage bigotry. As Abigal McCarthy (24) put it:

> I cannot be anything but moderate or marginal in my ethnicity without denying or degrading people with whom I share physical heritage. This must be true of millions of Americans.

The system pioneered by the NCUEA for developing ethnic/community models provides a tested means for enabling a community to deal with their own problem. By developing Ethnic Neighborhood Drug Council (ENDC) a basis for support and cooperation may be established in the neighborhood, so that instead of neighborhoods organizing against drug treatment programs brought in from the outside, they organize from within to develop programs to meet community needs. So developed, programs may gain legitimacy and community acceptance, reflecting in many ways the specific nature of the community.

This process is begun by bringing together community-wide leaders in training sessions designed to move toward a factual understanding and assessment of the community drug problem and possible solutions. At the same time the training fosters group process among leaders in the context of examining personal attitudes, values, etc., and helps them begin to learn about the developmental processes that lead to maturity. This procedure, which has been used in several communities, has proved effective in building a sound awareness of program philosophy as well as team cohesiveness among neighborhood project leaders. These strategies in turn can be applied to the training and development of program staff, the coordination of the network of community young people, as a means of insuring the program's viability, appropriateness and efficiency.

References

1. Barrabe, Paul and von Mering, Otto: "Ethnic Variation in Mental Stress in Families with Psychotic Children," *Social Problems* I (October, 1953).
2. Breton, Raymond: "Institutional Completeness of Ethnic Communities and the Personal Relations of Immigrants," *American Journal of Sociology*, Vol. 70, 1964, pp. 193-205.
3. Cantril, Albert H. and Roll, Charles W., Jr., *Hopes and Fears of the American People*, Universe Books (New York, 1971).
4. Dodson, W. E. *et al.*: "Patterns of Multiple Drug Abuse Among Adolescents Referred by a Juvenile Court," *Pediatrics*, 47: 1033-1036, 1971.
5. Fromm, Erich: *The Sane Society* (New York, 1955).
6. Giordano, Joseph: *Ethnicity and Mental Health* (New York, American Jewish Committee, 1973).
7. Giordano, Joseph: Testimony Submitted to the Select Committee on the Mental and Physically Handicapped, Nov. 21, 1974.
8. Glazer, N. and Moynihan, D. P.: *Ethnicity: Theory and Experience*, (Harvard, 1971).
9. Glazer, Nathan: "The Limits of Social Policy," *Commentary*, 52:3, September 1971.
10. Glenn, S. and Warner, J.: *The Developmental Approach to Preventing Problem Dependencies* (Social Systems, Inc., 1977).
11. Green, Gerson and Baroni, Geno: *Who's Left in the Neighborhood?*, National Center for Urban Ethnic Affairs for the Office of Minority Business Enterprises, 1976.
12. The Group School: *Neighborhood, Youth and Class: An Introductory High School Course on Ethnic and Class Identity* (The Group School and the National Center for Urban Ethnic Affairs, 1977).
13. Gurin, Gerald, Veroff, Joseph, and Field, Sheila: *Americans View Their Mental Health* (New York, John Wiley and Sons, 1958), p. 95.
14. Hollingshead, August and Redlich, Frederick: *Social Class and Mental Health* (New York, John Wiley and Sons, 1958), p. 95.
15. Kandel, D., Single, E., Kessler, R. C.: "The Epidemiology of Drug Use Among New York State High School Students: Distribution, Trends, and Change in Rates of Use," *American Journal of Public Health*, 66:43-53, 1976.
16. Kolm, Richard: *Bibliography on Ethnicity and Ethnic Groups* (National Institute of Mental Health, Rockville, MD, 1973).
17. Koloday, Ralph: "Ethnic Cleavages in the United States," *Social Work*, XIV (January 1969).
18. Kornhauser, Arthur: "The Mental Health of Factory Workers: A Detroit Study," *Human Organization*, Vol. 21, 1962.
19. Krug, S.E., Henry, T.J.: "Personality, Motivation and Adolescent Drug Use Patterns," *Journal of Consulting Psychology*, 21:440-445, 1974.
20. Leighton, Alexander: *My Name is Legion* (New York, Basic Books, 1959).
21. Levine, Irving M.: "Ethnicity and Mental Health," Institute for Human Relations, New York, 1973, p.r.
22. Levy, N.: "The Use of Drugs Among Teenagers," *Canadian Psychiatric Association Journal*, 17:31-36, 1972.
23. Litwok, Eugene: "Voluntary Associations and Neighborhood Cohesion," *Sociological Review*, 26:2, April 1961.
24. McCarthy, A.: "Our Search for Our Roots," *Commonwealth*, Vol. II, No. 3, April 1961.
25. Mills, John: *White Collar, The American Middle Classes* (New York, Oxford University Press, 1951).
26. Myers, Jerome and Bean, Lee: *A Decade Later: A Follow-Up of Social Class and Mental Illness* (New York, John Wiley and Sons, 1965).
27. National Institute on Drug Abuse: *Manpower and Training Strategy* (NIDA, Rockville, MD, 1977), p. 32.
28. National Youth Polydrug Study, Philadelphia Psychiatric Institute, 1977. Special data analysis performed for this chapter.
29. O'Donnell, J. A., *et al.*: *Young Men and Drugs—A Nationwide Survey*, NIDA Research Monograph 5 (National Institute on Drugbuse, Rockville, MD, 1976).
30. Opler, Marvin: *Culture and Social Psychiatry* (New York, Atherton Press, 1967).
31. Parsons, Talcott, "Some Theoretical Considerations on the Nature and Trends of Change of Ethnicity," in *Ethnicity, Theory and Experience*, edited by Glazer, Nathan and Moynihan, Daniel P. (Harvard University Press, 1976), pp. 53-83.

32. Phillips, Derek: "The True Prevalence of Mental Illness in a New England State," *Community Mental Health Journal*, 2:1, Spring 1966.
33. Rosencrans, C. J. Birgnet, H. P.: "Comparative Personality Profiles of Young Drug Abusers and Non-Users," *Alabama Journal of Medical Sciences*, 9:397-402, 1972.
34. Seltzer, C., Friedman, G.D., Suegelaub, A.B.: "Smoking and Drug Consumption in White, Black and Oriental Men and Women," *American Journal of Public Health*, 64: 466-473, 1974.
35. Slater, Philip: *The Pursuit of Loneliness: American Culture at the Breaking Point* (Boston, Beacon Press, 1970).
36. Spiegel, John: "Some Cultural Aspects of Transference and Counter-Transference," in *Social Welfare Institutions*, edited by M. W. Zold (New York, John Wiley and Sons, 1965).
37. Stole, Leo, Langner, Thomas, Michael, Stanley, Opler, Marvin, and Rennie, Thomas: *Mental Health in the Metropolis: The Midtown Manhattan Study* (New York, McGraw Hill, 1962).
38. Vaillant, G.: "Parent-Child Cultural Disparity and Drug Addiciton," *Journal of Nervous Mental Disorders*, 142:534-539, 1966.
39. Warren, Donald: "Neighborhoods in Urban Areas," *The Encyclopedia of Social Work*, 1971 (New York, NASW, 1971).
40. Yankelovich, Skelly and White, Inc.: *Students and Drugs*, Drug Abuse Council, Inc., Washington, D.C., 1975).
41. Zborowski, Mark: *People in Pain* (San Francisco, Jossy-Bass, 1964).

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